Personal Accident - Death

Claim Form

SG020

CHUBB

Important Information

1) Claimant is requested to state, as fully and accurately as possible, the information asked for below.

2) Please attach a Certified True Copy Death Certificate, Police Report, Coroner's Inquiry/Autopsy and Toxicology Report.

3) For group Personal Accident (Accidental Death) claim, please attach Documentary Proof of the Commencement Date of Employment and confirming that the Deceased was an employee of the Policyholder prior to the time of death (E.g. Certified True Copy of Pay Slip).

4) If death occurred overseas, please attach burial/cremation documentation and letter from Immigration & Checkpoints Authority (ICA) confirming the invalidation of Deceased's Singapore NRIC/Passport. Documents must be authenticated by either of the following:

i) Singapore Embassy in the country of death;

ii) Singapore Consulate; or

iii) Notary Public.

5) All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

6) Any documentary proof and/or other reports required by Chubb Insurance Singapore Limited (Chubb) shall be furnished at the expense of the Claimant.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb or waiver of its rights.

Section A: Particulars of Policyholder / Deceased and Claimant

Name of Policyholder (as shown in NRIC / Passport)

_____

Address of Policyholder

_____

_____ Postal Code _____

Policy No. _____

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

Tel No. (Mobile) _____ Tel No. (Residence) _____

Tel No. (Office) _____ Marital Status ☐ Single ☐ Married ☐ Widowed

Date of Birth DD / MM / YYYY Age _____

Gender ☐ Male ☐ Female Relationship to Deceased (if applicable) _____

Occupation _____ Date of Employment DD / MM / YYYY

Name of Employer _____

Date of Death (if applicable) DD / MM / YYYY Place of Death (if applicable) _____

Cause of Death (if applicable) _____

Name of Deceased (as shown in NRIC / Passport) - if Deceased and Policyholder are two different persons

_____

Address of Deceased

_____

_____ Postal Code _____

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed

Date of Birth DD / MM / YYYY Age _____

Date of Death DD / MM / YYYY Place of Death _____

Cause of Death

_____

Occupation _____ Date of Employment DD / MM / YYYY

Name of Employer _____

Basis of Insurance / Category of Deceased Covered

_____

Please provide details of every physician who has attended to the Deceased in the last five years and state the nature of illness and / or disease. (Please use supplementary sheet if necessary)

Name of Physician	Address of Physician	Nature of Illness

Was the Deceased holding any life, personal accident and / or hospitalisation policy / policies with any other insurance companies?
If **Yes**, please furnish with details below (Please use supplementary sheet if necessary)

Name of Insurance Company	Policy Type	Date Insurance Effected	Amount Insured

Name of Claimant (as shown in NRIC / Passport) - if different from Policyholder

_____

Address of Claimant

_____

_____ Postal Code _____

NRIC / Passport No. _____ Occupation _____

Nationality _____ Age _____

Tel No. (Mobile) _____ Tel No. (Residence) _____

Tel No. (Office) _____ Gender ☐ Male ☐ Female

Date of Birth DD / MM / YYYY Relationship to Deceased _____

Email _____

Section B: Details of Accident

Date of the Accident DD / MM / YYYY Time of Accident H H : M M

Country of Accident _____ Place of Accident _____

When and Who discovered the Accident _____

Relationship of person to the Deceased _____

Chronology and Description of the Accident (Please use supplementary sheet if necessary)

_____

_____

_____

Were there witnesses to the incident at the material time? ☐Yes ☐No
If **Yes**, please provide details below

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐Yes ☐No
If **Yes**, please provide details below (Please use supplementary sheet if necessary)

Name / Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date And Time Consumed

Has this accident been reported to the Ministry of Manpower (MOM)? ☐Yes (please attach a copy of the I-REPORT) ☐No
If **No**, please state reason(s) the accident was not reported to the MOM:

Please provide details of the Police Station to which the accident was reported to and attach the police report:

Name of Police Station _____

Date of Report DD / MM / YYYY Time of Report (24-Hour) H H : M M

Was the deceased admitted to a hospital prior to death? ☐Yes ☐No
If **Yes**, please provide details of the Hospital and attach the medical report:

Name of Hospital _____

Address of Hospital

_____ Postal Code _____

Section C: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Death Certificate, Police Report, Medical Report, Completed Attending Physician's Statement	☐	☐
Autopsy Report, Post Mortem Report, Toxicology Report	☐	☐
Coroner's Inquiry Report; Police Investigation reports & findings on the alleged accident; and Incident Report lodged by the employer (if applicable)	☐	☐
Driving License (if deceased was driving at the time of accident)	☐	☐
Letter of Administration or Receipt of Probate (if applicable)	☐	☐

All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator or interpreter.

By signing this form, I agree that Chubb will use the information supplied here and during the formation and performance of the policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I hereby authorise any hospital, physician, and any other person(s) or entity who has attended to or examined the deceased, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

_____

Signature of Policyholder
(Please affix company stamp if applicable)

_____

Date

_____

Signature of Claimant
(if different from Policyholder)

_____

Date

_____

Name & Signature of Insured's Direct Manager (for corporate policies)

_____

Date

Note:

Kindly submit the completed claim form through your Broker or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

Contact Us

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Section D: Attending Physician's Statement (To be completed by attending physician)

Name of Patient _____

NRIC / Passport No. _____ Gender ☐Male ☐Female Date of Birth DD / MM / YYYY

Date on which you first saw the Patient DD / MM / YYYY

Is it due to Sickness or Injury? ☐Sickness ☐Accident on DD / MM / YYYY

Was the Patient referred to you by another doctor? If so, please furnish with Name and Address of Referral doctor

Name of Doctor _____

Address _____

What symptoms did the Patient complain of?

_____

According to the Patient, how long had he / she been experiencing these symptoms?

_____

In your opinion, how long do you feel the symptoms had lasted?

_____

Had the Patient previously seen any other doctor or receive treatment on account of these symptoms?
If so, please give details:

_____

What was the primary caused of death?

_____

Was there any other significant conditions or illness(es) which may have contributed to the death? ☐No ☐Yes
If **Yes**, please provide details:

_____

Give details of any circumstances, such as the influence of alcohol, or any other drugs and substances which may have contributed to the death.

_____

_____

_____

_____

Was the death due to deliberately self-inflicted injury, suicide, or criminal or illegal acts?
If **Yes**, please provide details:

_____

_____

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his / her condition.

_____ _____

Name of Physician Qualification

Official Address

_____

_____

Tel / Fax _____

_____ _____

Signature with Official Stamp Date

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